involving rare cancers. The increased life expectancy of HAART treated patients, a direct involvement of HIV itself, or abnormalities driven by oncogenic viruses, including EBV, HSV-8, and papillomavirus,[1 2] might explain the tendency to develop a broader spectrum of long term neoplastic complications. In our experience, a persistent HIV associated immunodeficiency and an incomplete virological response to HAART, possibly had a pathogenetic role. Clinicians should maintain an elevated clinical suspicion for a broad spectrum of HIV associated cancer, even after a first diagnosis of AIDS related neoplasm. Epidemiological studies should give a reliable estimate of the frequency of all HIV associated tumours, and recognise eventual dual AIDS associated cancers. The pathogenesis underlying AIDS related malignancies (especially neoplasm immunity and viral oncogenesis) deserve careful insight.

Contributors

RM collected and interpreted data and literature evidences, and drafted the entire work; LC collected clinical and laboratory data and literature evidences, and revised both data evaluation and discussion; FC proposed and supervised the report, read and corrected the draft, and participated in the discussion of both data and literature references

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Impact of the Sexually Transmitted Infections Foundation course on the knowledge of family planning nurses and doctors

There has been convergence of genitourinary medicine and reproductive healthcare services in the United Kingdom to produce "one stop sexual health clinics" such as the Sandyford Initiative in Glasgow.[1–3] As part of service development a number of educational initiatives such as the Sexually Transmitted Infection Foundation (STIF) course have been initiated to ensure that minimum skills and competencies are obtained. Training programmes such as the STIF course coordinated by the Medical Society for the Study of Venereal Diseases (MSSVD) play a vital part in providing staff with the education required to competently extend their roles. The first Scottish STIF course was run in Glasgow in March 2002. The course was developed as a UK-wide initiative to support the implementation of the English national strategy for sexual health and HIV.[4]

Table 1 The mean (SD), median precourse and post-course scores, and mean difference in scores

	Precourse score	Post-course score	Mean difference (95% CI)
All participants (n=18)			
Mean (SD)	8.2 (2.3)	10.7 (1.8)	+2.5 (1.1 to 3.9)
Median	9.0	12.0	
Doctors (n=15)			
Mean (SD)	8.6 (1.9)	10.6 (1.8)	+2.0 (0.7 to 3.3)
Median	9.0	12.0	
Nurses (n=3)			
Mean (SD)	6.0 (3.0)	11.0 (1.7)	+5.0 (–3.6 to 13.6)
Median	6.0	12.0	

In order to evaluate the impact attendance at the STIF course had on the knowledge of family planning staff, a prospective study was performed in Glasgow. Eighteen members of family planning staff (15 doctors and three nurses) were assessed on their knowledge of vaginal and cervical infections before and after attendance at the course, using four clinical case scenarios with accompanying clinical pictures. A maximum score of 12 was awarded for each assessment. The cases comprised candida, trichomonas, bacterial vaginosis, and chlamydia. The participants were asked to provide a provisional diagnosis based on the history and a clinical picture. The vaginal pH was then provided and each participant was given the opportunity to alter their diagnosis in the light of this additional information. They were then asked about the management of each condition. Within 3 months of the STIF course, each doctor and nurse were retested with the initial scenarios. Answers and feedback were provided on completion.

Two sample *t* tests and confidence intervals for the difference of two means were employed to compare all participants and the doctors and nurses scores before and after attendance at the STIF course. One sample *t* tests and confidence intervals for the difference of two means were employed to compare the doctors and nurses scores. As the numbers in the study were small a subanalysis of the results for different grades of doctors was not performed. Table 1 shows the mean (SD), median precourse and post-course scores, and mean difference in scores. The mean increases in all participants' and the doctors' scores were statistically significant ($p = 0.001$, and $p = 0.006$, respectively). The mean increase in the nurses' score was 5.0 (95% CI −3.6 to 13.6), however the number of nurse participants was small (n=3).

This study suggests that knowledge increased following attendance at the STIF course. Educational initiatives such as the STIF course are important tools for development of staff working in the field of sexual and reproductive health care. A larger study of this type assessing a wider range of subject matter with longer follow up would enable further evaluation of the STIF courses' impact on knowledge.

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Improving response rates for self collected urine samples

Chlamydia trachomatis is the commonest bacterial sexually transmitted infection (STI) in Victoria, Australia, with the number of notifications increasing threefold in the past 8 years from 1287 in 1994 to 3977 in 2001.[1] As infection with chlamydia is frequently asymptomatic, notification data underestimate population prevalence. Innovative study designs are necessary to investigate chlamydia prevalence and risk factors. We conducted a pilot study among women aged 18–32, to estimate the rate of response to a request to provide a mailed self collected urine specimen for chlamydia testing. Recruitment via mail was compared with recruitment via mail and follow up telephone contact.

Between March and May 2002, the names and addresses of 150 Victorian women aged 18–32 were randomly selected from the electoral roll. These were linked with the Electronic White Pages and telephone numbers obtained where possible, producing two groups: (1) women with telephone numbers identified, and (2) women without telephone numbers identified. All women were mailed a letter of invitation and an information leaflet. Women in group 2 were also mailed a reply paid participation form asking them to indicate whether they wished to participate.

Women in group 1 were telephoned after 1 week and consent sought to mail them a urine kit. Two reminder letters were sent to non-responders in group 2. Women testing positive

Table 1 Response rates by age and method of recruitment

	18–22 years No (%)	23–27 years No (%)	28–32 years No (%)	Total No (%)
Group 1 Mail and telephone:				
Number	26 (100)	21 (100)	18 (100)	65 (100)
Agreed to participate	14 (54)	14 (67)	7 (39)	35 (54)
Urine provided	10 (38)	12 (57)	7 (39)	29 (45)
Group 2 Mail:				
Number	16 (100)	26 (100)	27 (100)	69 (100)
Agreed to participate	2 (13)	6 (23)	8 (30)	16 (23)
Urine provided	2 (13)	5 (19)	7 (26)	14 (20)
Total	12 (29)	17 (36)	14 (31)	43 (32)

were treated with azithromycin through their nominated doctor.

Participants provided 20 ml first void urine in the container provided. Specimens were tested for chlamydia by polymerase chain reaction.

Telephone numbers were found for 70 (47%) women. Among women in group 1, five (7%) were excluded because they were living overseas. Of the remaining 65 women, 35 (54%, 95% CI 41 to 66) agreed to participate and 29 (45%, 95% CI 32 to 57) provided a specimen. One case of chlamydia was diagnosed giving a prevalence of 3.4% (95% CI 0.1 to 17.8) in this group (table 1). Among women in group 2, 11 (14%) were excluded because they were not living at their registered address. Of the remaining 69 women, 16 (23%, 95% CI 14 to 35) agreed to participate and 14 (20%, 95% CI 12 to 32) provided a specimen. No cases of chlamydia were diagnosed.

In this pilot study we showed recruitment via mail and telephone had a significantly higher response than mail alone (45% *v* 20%, p=0.002). This suggests that telephone communication will increase response in population based chlamydia research that uses mail contact as the principal recruitment tool. Although the method of recruitment was not randomly allocated, the 25% difference in response is unlikely to be explained by differences between the two groups.

A response rate of 45% for those recruited via mail and telephone compares well with results obtained in similar overseas studies.[2–4] However, unlike our study that used the electoral roll as the sampling frame, these studies used a primary healthcare sampling frame, not available in Australia. As we were only able to locate telephone numbers for 47%, an alternative sampling frame would be necessary for future research using mailed, self collected specimens.

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Contributors

JH, conducted the pilot study and drafted the letter; ST, conception and design particularly with reference to specimen collection and conducted all chlamydia testing; DJ, conception and design particularly with reference to population sampling and statistical methods and reviewed and made revisions to the letter; SG, conception and design of study, assisted with the ethics application and reviewed and made revisions to the letter; CF, conception and design, assisted with the ethics application and revised letter critically for important intellectual content.

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Which factors affect access to STD care? A comparison of a hospital based clinic and an outreach service

The national strategy for sexual health and HIV recommends that genitourinary medicine (GUM) outreach services be used as a means of expanding patient access to testing and advice for STDs.[1] However, there is limited published work to demonstrate the effectiveness of outreach services in GUM.[2 3] Having established an outreach GUM service in 1997 we reported initial data in 1998[4] and now we report a more in-depth examination of the factors that affect access to care and a further evaluation of the differences between patients attending the outreach and main clinics.

The Patrick Clements Clinic is a long established hospital based GUM clinic (about 16 000 attendances per year) in north west London. It offers a daily, weekday, open access, walk-in service. The Windsor Clinic (WC) is an outreach GUM service based at a GP practice building in Wembley. It opens one afternoon a week with mixed appointment and walk-in slots, staffed by a consultant and a nurse.

Fifty five patients were interviewed at the two study sites: 35 at the main clinic and 20 at the outreach clinic. The taped interviews were later analysed to look for themes. Demographic and disease data were also analysed from consecutive attendees for a week at the hospital clinic and 6 months at the outreach clinic using the clinic database. Data were compared with the previously published study.[4] Differences were tested with the χ^2 test.

The most notable differences between interviewees were the higher rate of previous GUM attendance, 28/35 (80%) *v* 5/20 (25%),

Table 1 Comparison of demographic and disease data on patients attending the two clinics in 2001 and significant data from the 1998 survey

Variable	Hospital clinic patients (209) No (%)	Outreach clinic patients (111) No (%)	Outreach clinic data (95) 1998[4]
Ethnicity			
Asian	11 (5)	5 (5)	17 (17.4)**
Black British/Caribbean	77 (37)	48 (43)	
White	54 (26)	23 (21)	
African	14 (7)	18 (16)*	
First time attendees	72 (34)	66 (59)*	
Women	107 (51)	75 (68)*	
Men	102 (49)	36 (32)*	
Median age	28	26	26**
Age <20 years	22 (11)	21 (19)*	19 (20)**
Disease			
Gonorrhoea	7 (3)	5 (5)	
Chlamydia	12 (6)	9 (8)	
Trichomoniasis (female)	4 (4)	1 (1)	
NGU (male)	15 (15)	3 (8)	
Genital herpes	5 (2)	0	
Genital warts	12 (6)	3 (3)	
HIV test	64 (31)	30 (27)	27 (28)**

*p<0.05, outreach *v* hospital clinic patients for 2001 data.
**p<0.05, 95 outreach *v* 105 hospital clinic patients, data collected in 1998 for both.[4]